



DELAWARE HEALTH AND SOCIAL SERVICES
 Division of Public Health
 544 S. Bedford Street, Georgetown, DE 19947

Influenza and Pneumococcal Vaccine Administration Record

Name: _____ Sex: F _____ M _____ Phone: (____) _____
Last First MI

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth ____/____/____ Age _____ Insurance: Medicare _____ Medicaid _____ None _____ Other _____ Hispanic Ethnicity: Yes _____ No _____

Race (Check all that apply): White _____ Black _____ Asian _____ Native Hawaiian/Pacific Islander _____ American Indian/Alaskan Native _____

How did you find out about this event? ☐ Newspaper ☐ Radio ☐ Poster/Flyer ☐ DPH Website ☐ Friend/Family ☐ E-mail / Electronic Newsletter

Medical Screening

Does the person to be vaccinated have any of the following conditions?

No _____ Yes _____

Clinician's Note

- Chronic lung disease (including asthma or COPD) and/or is a smoker
- Neurologic conditions
- Heart disease (excluding high blood pressure)
- Disorders of blood, kidneys, liver or metabolic diseases (including diabetes mellitus)
- Weakened immune system (because of a disease or condition, long-term steroids, or cancer treatments)
- Under age 19 and on long-term aspirin therapy
- Morbidly obese

Is the person to be vaccinated pregnant?

No _____ Yes _____

Is the person to be vaccinated sick today?

No _____ Yes _____

Has the person to be vaccinated ever had a serious reaction to a previous dose of influenza or pneumococcal vaccine?

No _____ Yes _____

Has the person to be vaccinated ever had a serious allergic reaction to:

No _____ Yes _____

- Eggs, egg proteins or a previous influenza vaccination,
- Natural rubber latex; or other substances? _____

Has the person to be vaccinated ever had Guillain-Barré syndrome?

No _____ Yes _____

Mark the type(s) of vaccine that you are requesting Influenza (for Flu) _____ Pneumococcal (for Pneumonia) _____
(available only at select clinic sites)

Complete the next section and sign after you have talked with the clinician

A check next to the vaccine type(s) above and my signature (below) means that I have been given a copy of the appropriate Vaccine Information Statement (VIS) and have read, or have had explained to me, information about the disease(s) and the vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the VIS I was given and I ask that the vaccine(s), as marked, be given.

Signature _____
 Patient _____ Parent _____ Guardian _____

Signer's Name _____
 Date _____ Print Clearly

Do not write below this line. For Clinician use only.

NHS _____ SHS _____	Clinic Location: _____
Presentation/Route LAIV / Nasal _____	Dose 0.2ml _____
IIV / IM _____	0.25ml _____ 0.5ml _____
IIV / ID _____	0.1ml _____
Vaccination Date (MM/DD/YYYY)	Manufacturer <u>Sanofi, MedImmune, GSK</u> Lot # _____ <small>Circle one</small>

VIS Date 7/26/2013 Date Given _____

VIS Date 7/26/2013 Date Given _____

Presentation/Route Pneumo / IM _____ SC _____	Dose 0.5ml _____
Vaccination Date (MM/DD/YYYY)	Manufacturer <u>Merck</u> Lot # _____

VIS Date 10/6/2009 Date Given _____

Clinician's Signature: _____ License Title _____ Doc # 35-05-20/13/09/05

Name _____ Date of Birth _____
 Last First MI

For Nasal Mist Vaccine Only

Answer these questions only if the person to be vaccinated is age 2-49 and prefers a vaccine that is sprayed into the nose (nostrils) instead of injected in the arm

	No	Yes	Clinician's Note
Is the person to be vaccinated sick today?			
Is the person to be vaccinated pregnant or could she become pregnant within the next month?			
Is the person to be vaccinated younger than 2 or older than age 49?			
If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?			
Has the person to be vaccinated ever had a serious reaction to intranasal flu vaccine (FluMist)?			
Has the person to be vaccinated ever had a serious allergic reaction to: <ul style="list-style-type: none"> Eggs, egg proteins or a previous influenza vaccination, or Other vaccine components such as gentamicin, gelatin, or arginine? 			
Has the person to be vaccinated received any other vaccinations in the past 4 weeks?			
Is the person to be vaccinated receiving anti-viral medications?			
Is the person to be vaccinated a child or adolescent on long-term aspirin therapy?			
Has the person to be vaccinated ever had Guillain-Barré syndrome?			
Does the person to be vaccinated:			
Have long-term health problem with heart disease, lung disease, asthma, kidney or liver disease, metabolic disease (such as diabetes), anemia, or other blood disorders?			
Have muscle or nerve disorders (such as seizure disorders or cerebral palsy) that can lead to breathing or swallowing problems?			
Have cancer, leukemia, HIV/AIDS or another disease that affects the immune system, or, in the past 3 months, taken medications that weaken the immune system such as cortisone, steroids, or anti-cancer drugs; or have had radiation treatments?			
Live in or have close contact with someone whose immune system is so weak he or she requires care in a protected environment (such as a bone marrow transplant unit)?			

Signature _____ Signer's Name _____
 Patient _____ Parent _____ Guardian _____ Date _____ Print Clearly

Official Use Only

- ☐ **VFC** – Child is under age 19 and
- ☐ Child is enrolled in Medicaid or DHCP
 - ☐ or Child is uninsured
 - ☐ or Child is American Indian or Native Alaskan
- ☐ **Non-VFC** – Child does not meet VFC qualifications above